Dr. Joseph P. Cheff, DC

CHEFF CHIROPRACTIC CARE

Personal Information

Date of Birth_____/_____/_____ Sex: M F Date____/____/_____

Name _____ Email _____

Address_____**City**_____

State_____ **Zip**_____

Phone(H)_____**Phone(W)**_____ **Cell**_____

Marital Status S M D W Spouse's Name_____

Number of Children_____ **Ages**_____

Preferred Reminder Method: TEXT or EMAIL

Referred By _____

Emergency Contact

Name _____
Relationship _____
Phone # s _____

I _____ **have read all of the above and understand completely. I have been truthful in all of my statements and information above.**

Signature_____ **Date**_____/_____/_____

CHEFF CHIROPRACTIC CARE

RELEASE OF INFORMATION

By signing this form, you are granting consent to Cheff Chiropractic Care to request and disclose your protected health information for the purposes of treatment, payment and health operations. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices (NOPP) before you sign this consent, and we encourage you to read it in full. Our NOPP is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (540) 459-3900. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we decide to grant your request, we are bound by our agreement.

_____ _____

Signature Date

MEDICARE CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim.

_____ _____

Signature Date

VERIFICATION OF NON PREGNANCY (Female patients only)

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____

_____ _____

Signature Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

MEDICAL AUTHORIZATION

I, _____ do hereby authorize you to release any and all information concerning myself, including x-rays, medical reports, clinical reports, or other related documents acquired in the course of my examination understanding they are a part of your permanent records.

_____ _____

Signature Date

Name_____ Date _____ Zip_____

Age _____ DOB: _____
Occupation/Position_____

Marital Status: S M D W Number of Children and Ages: _____

Reason for Visit: _____ Pain Relief _____ Improve Functional Disability ____ Continue Wellness Care
EXPLAIN:

When did the pain start?	Have you had it before? When?
Since the pain started, is it: Better ___ Same ___ Worse ___	What makes it better?
Home Remedies You've Tried:	What makes it worse?

As a result of my Chiropractic Care, I would like to: ____Feel better quickly ____Have a healthier spine ____Have a healthier body and Nervous System _____Live a healthier lifestyle

Other Doctors you've seen for this condition:	Who/When/Where?
Have you seen a Chiropractor before?	Who/When/For What?
List ALL surgeries and year	
List ALL car accidents and year	
List ALL major falls/ broken bones and year	
How do you like to spend your free time?	

List ALL Nutritional supplements

Name of Supplement	Dosage and Frequency

List ALL Medications you are taking
(Name and mg)

Name of Medication	Dosage and Frequency

List Allergies to Medications

Medication Name	Reaction

Do you smoke?

_____ Yes, every day ____ Yes, some days _____ No, former smoker
_____ No, never smoked

CHEFF CHIROPRACTIC CARE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. Regardless of what disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **Our ONLY practice objective is to eliminate a major interference to the nervous system and thus improve the expression of the body's innate wisdom.** Our only method of doing so is the specific adjustment of the spine to correct vertebral subluxations. It is important that you, the patient, understand the specific terms used to describe this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

CHEFF CHIROPRACTIC CARE

Office Fee Schedule and Financial Policy

Service	Regular Fee	
Consultations	Range: $0.00 - $50.00	
Initial Exam	$150.00	
X-Rays (per view)	$50.00	
Periodic Re-Exam	Range: $25.00 - $50.00	
Adjustment	$60.00	65 yr or older $50.00
Therapeutic/Rehab Services	$25.00 - $40.00	
Missed Appt Fee (w/out 24 hr notice)	$30.00	

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service. Should you need to cancel an appointment, we do ask for a **24 hour advance notice. If you cancel without giving 24 hrs advance notice, or miss it altogether, you will be assessed a $30 fee.** Thank you for your courtesy of giving someone else the opportunity to receive chiropractic care.

[ ] Insurance: If you have health insurance that covers chiropractic and choose to use it, you will be charged the regular fees listed above. We do not file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. We do not participate with any 3rd party payers or insurance companies. We will provide you with the necessary documentation for you to submit your own claim.

[ ] At your Request: we will provide you with a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for your chiropractic care during the year, There is no insurance documentation given with these receipts.

I, _____ have read and I understand the above policies. I have initialed the fee option that applies to me. I understand that I am responsible for the fees incurred at this office, regardless of my status with my insurance company. I agree to pay all fees associated with collecting my balance, should it become necessary to involve a third party company.

_____ _____

Signature Date